PHARMACY BENEFIT MANAGER DATA SHARING AGREEMENT

This Pharmacy Benefit Manager (PBM) Data Sharing Agreement (the "Agreement") for the exchange of enrollment information is entered into between (Insert PBM Name), with its principal address at (Insert PBM Address) (the "PBM") and the United States Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services ("CMS") (the "Parties") on this ___th day of _____, 20__ (the "Effective Date").

RECITALS

I. MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003 AND SUBSEQUENT REGULATIONS, AND THEIR IMPACT ON PBMs

The Medicare Prescription Drug, Improvement, and Modernization Act (the Medicare Modernization Act, or MMA) was enacted in 2003. Included in the MMA is a new prescription drug benefit, referred to as Medicare Part D. Under provisions found in § 1860D-2(a) (4) of the MMA, the Medicare Secondary Payer (MSP) rules have been incorporated in the MMA and apply to prescription drug coverage in the same manner as they apply to hospital and medical coverage. Part D establishes access through beneficiary enrollment in coverage provided by private sector Prescription Drug Plans (PDPs) and through beneficiary enrollment in Medicare Advantage plans that include a prescription drug benefit (MA-PDs). The MMA also contains a new retiree drug subsidy that is designed to encourage employers and unions to continue providing prescription drug coverage for their retirees. Under the new law, employers and unions that offer drug coverage that is as good as or better than Medicare's defined standard prescription drug benefit under Part D will be eligible for a retiree drug subsidy. Finally, the MMA introduces a requirement that PDPs and MA-PDs keep track of the TrOOP – "true out-of-pocket" spending – made by Part D beneficiaries.

Due to the expansion of COB data collection processes as a result of the MMA, PBM clients such as employers and insurers have new coordination requirements in their data sharing agreements with CMS which include providing prescription drug coverage information. Because many employer and insurer clients do not have the data necessary to coordinate prescription drug information, they are looking to PBMs to help them fulfill such obligations by entering into data exchanges with CMS on their behalf.

PBMs that enter into the Agreement) can use it to determine the Medicare program eligibility of individuals who are enrolled in health insurance plans that include prescription drug benefits authorized by the MMA. Data exchange procedures can quickly clarify appropriate participation, coverage and payment responsibility determinations. Participation in the Agreement will also help the PBM assist in the accurate and timely calculation and tracking of beneficiary True Out-of-Pocket (TrOOP) spending. Finally, current regulations specifically authorize the use of a VDSA as an

alternative method of providing retiree drug subsidy enrollment files to the Retiree Drug Subsidy (RDS) Contractor.

II. THE MEDICARE SECONDARY PAYER PROGRAM

The sections of the Social Security Act known as the Medicare Secondary Payer (MSP) provisions were originally enacted in the early 1980s. Since then, MSP law has been repeatedly amended by Congress and CMS has promulgated several sets of regulations concerning the MSP laws. The current MSP regulations, codified at 42 C.F.R. § 411.20 et. seq., created a change in the administration of Medicare program secondary payer determinations. MSP refers to the term used by Medicare when it is not responsible for paying first for a Medicare beneficiary because the beneficiary has other insurance which is primary to Medicare.

Under provisions found in § 1860D-2(a) (4) of the MMA, the Medicare Secondary Payer (MSP) rules have been incorporated in the MMA and apply to prescription drug coverage in the same manner as they apply to hospital and medical coverage.

III. PURPOSE OF AGREEMENT

The CMS and the PBM seek to more efficiently coordinate health care benefit payments between them in accordance with the MSP, MMA and other Medicare-related laws. The purpose of this Agreement is to establish and describe conditions under which the PBM and CMS agree to exchange health care coverage enrollment data. PBMs, through this exchange will receive Medicare entitlement data. Specifically, the PBM seeks to:

1. satisfy the requirement of its Employer and Insurer clients that have entered into Voluntary Data Sharing Agreements (VDSAs) with CMS by reporting prescription drug coverage that is primary or secondary to Medicare Part D according to the MSP rules;

2. satisfy the requirement of its Employer and Insurer clients that have entered into Coordination of Benefits Agreements (COBAs) with CMS to report prescription drug coverage that is supplemental to Medicare Part D;

3. report, prescription drug coverage that is primary or secondary to Medicare Part D for its employer or insurer clients that have not entered data sharing agreements with CMS; and

4. report, prescription drug coverage that is primary or secondary to Medicare Part D for its clients that have entered into a data sharing agreement with CMS.

Generally, the PBM agrees to provide CMS with specified data describing its covered individual population. CMS agrees to provide the PBM with Medicare entitlement data. Examples of the data to be exchanged are more specifically described in the Input and

Response File Layouts, Attachments A through C. The process through which these data will be exchanged is described in TERMS AND CONDITIONS, Sections A through O, below.

IV. PBM DATA SHARING AGREEMENT DATA SHARING USER GUIDE

A "PBM Data Sharing Agreement User Guide" has been produced to accompany this Agreement, and is incorporated herein by reference as the "User Guide". The User Guide, found at Attachment E, is designed to accommodate the ordinary process changes and revisions that result from ongoing program operations. Current operational versions of the input and response data illustrated in Attachments A through C can be found in the User Guide.

V. DEFINITIONS

NOTE: These definitions are informational. While they accurately describe the terms being defined, they should not be construed as incorporating the force of regulation.

1. "Pharmacy Benefit Manager (PBM)" refers to those private companies that administer pharmacy benefits and manage the purchasing, dispensing and reimbursing of prescription drugs.

2. "Active Employee" shall mean an individual who satisfies the requirements of current employee status as explained at 42 C.F.R. § 411.104.

3. "Active Covered Individuals" are, for the purpose of this Agreement, defined as those Active Employees, spouses and dependents who are enrolled in an employer Group Health Plan ("GHP") and who are, at a minimum, no younger than 55 years of age.

4. "Agent" shall mean an individual or entity authorized by the PBM to act on the PBM's behalf for purposes of administering this Agreement. For purposes of this Agreement, all actions undertaken by the agent in administering this Agreement on behalf of the PBM shall be binding on the PBM.

5. "Coordination of Benefits Agreement (COBA)" refers to the standardized agreements between the CMS and other health insurers, and Medicaid State Agencies and their fiscal agents, for the electronic exchange of eligibility and paid claims data used to coordinate correct health claim benefit payments by Medicare and other insurers. A PBM, acting as an agent for its Employers or Insurers that have already signed a COBA with CMS has the option of reporting drug coverage information using either the VDSA process or the COBA process.

6. "Covered Individual" shall mean any individual enrolled in a health plan or policy, including but not limited to a group health plan or policy, for which the

PBM acts as a benefit administrator, health plan sponsor, insurer or any combination thereof.

7. "Customer" shall mean any person or entity for whom, or for which, a PBM provides health care financing or benefit administrator services.

8. "Group Health Plan (GHP)" is defined in 42 C.F.R. § 411.101 for purposes of this Agreement. Generally, a GHP is a health insurance benefit program made available to employees (and, often, their dependents) by an employer.

9. "Inactive Covered Individuals" are, for the purpose of this Agreement, defined as any "Covered Individuals" – individuals enrolled in a health plan or policy, including but not limited to a group health plan or policy, for which the PBM or its Subsidiary acts as an insurer, third party administrator, health plan sponsor or any combination thereof – and who cannot be classified as Active Covered Individuals. See, generally, 42 C.F.R § 411.104.

10. "MSP Input File" is a data set transmitted from a PBM to CMS that consists of data elements pertaining to health care coverage information of the PBM's Active Covered Individuals.

11. "MSP Response File" is a data set transmitted from CMS to a PBM after the data supplied in the PBM's MSP Input File has been processed. The MSP Response File is the CMS reply to the data supplied or information sought in the MSP Input File.

12. "Non-Medicare prescription drug Coverage" refers to other prescription drug coverage either primary or secondary to Medicare Part D.

13. "Non-MSP Input File" is a data set transmitted from a PBM to CMS that consists of data elements pertaining to health care coverage information of the PBM's Inactive Covered Individuals.

14. "Non-MSP Response File" is a data set transmitted from CMS to a PBM after the data supplied in the PBM's Non-MSP Input File has been processed. The Non-MSP Response File is the CMS reply to the data supplied or information sought in the Non-MSP Input File.

15. "Payer" refers to an entity that is responsible for paying for medical treatments including prescription drugs.

16. "Pharmacy Benefit Manager (PBM) Data Sharing Agreement" refers to the agreement between PBMs and CMS to exchange Non-Medicare prescription drug coverage data and Medicare Part D entitlement data in order to coordinate the prescription drug benefits of Medicare Part D Enrollees.

17. "Retiree" shall mean Qualifying Covered Retiree, a Part D eligible individual who is not enrolled in a Part D plan, and who is a participant (or the spouse or dependent of a participant) covered under employment-based retiree health coverage that is a "qualified retiree prescription drug plan" (a subsidy-eligible employer pharmacy benefit plan).

18. "State Pharmaceutical Assistance Program (SPAP)"-- refers to a State program which meets the requirements as set forth in 1860 D-23(b) of the MMA and subsequent regulations.

19. "Subsidiary" shall mean those subsidiaries and affiliate licensees of the PBM.

20. "TIN Reference File" is a data set transmitted from a PBM to CMS containing required PBM, group health plan, third party administrator, other plan sponsor and claims processor Tax Identification Number information.

21. "Voluntary Data Sharing Agreement (VDSA)" refers to the agreement between the CMS and employers or insurers to electronically exchange Medicare and group health plan (GHP) eligibility information, including prescription drug data.

TERMS AND CONDITIONS

In consideration of the mutual promises and representations set forth in this Agreement, the Parties agree as follows:

A. PREPARATORY PERIOD AND TEST PROCEDURES FOR COVERED INDIVIDUALS

Within ten (10) business days, or as soon as is practicable after the effective date of this Agreement, CMS, the CMS Coordination of Benefits (COB) contractor and the PBM will discuss the operational terms of the Agreement. Issue areas covered during this Preparatory Period shall include data requirements, file submissions, review of error codes, and other matters, as necessary. All parties will endeavor to resolve problems identified during Preparatory Period discussions within thirty (30) business days following the effective date of the Agreement.

The PBM acknowledges that the parties to this Agreement cannot proceed to full production file exchange until test file exchanges have been completed to the satisfaction of both CMS and the PBM. Prior to submitting its Initial MSP and Non-MSP Input Files, the PBM shall submit a Test Initial MSP Input File and a Test Initial Non-MSP Input File to CMS, receive a Test MSP Response File and a Test Non-MSP Response File in return, correct errors identified by CMS in the Test Initial MSP and Non-MSP Input Files, and add new Enrollees in Test Ongoing MSP and Non-MSP Input Files. The Test process is described in detail in the User Guide.

After successfully completing the Test process, the Initial Input File shall be submitted in accordance with provisions in Sections C and D, below.

B. PRIMARY PAYER DETERMINATION FOR COVERED INDIVIDUALS

The PBM shall identify those Covered Individuals, as defined in Section V. of this Agreement, in accordance with the process described in "C" and "D" below. In accordance with the process described in "C" below, CMS shall identify those Active Covered Individuals who are Medicare beneficiaries for whom Medicare assumes primary or secondary payment responsibility, based on coverage enrollment information received from the PBM. In accordance with the process described in "D" below, CMS shall identify those Inactive Covered Individuals for whom Medicare assumes primary payment responsibility.

C. CONTINUING ELECTRONIC DATA EXCHANGE BETWEEN PBMS AND CMS

1. Continuing electronic data exchange for Medicare Secondary Payer (MSP) reporting

PBMs will have the option of submitting MSP Input Files in the record layout found at Attachment A and receiving MSP Response Files on a quarterly or monthly basis in the record layout found at Attachment C. Using the Agreement Implementation Questionnaire found at Section O, Attachment D of this Agreement, the PBM shall indicate whether it will submit MSP Input Files on a quarterly or monthly basis. The User Guide that accompanies this Agreement contains the specific file submission protocols for each process described below.

a. Within forty-five (45)/fifteen (15) days of the completion of the process described in Section A (the "Preparatory Period"), the PBM shall provide to CMS a file containing the data elements included in the record layout found at Attachment A, with respect to Active Covered Individuals ("MSP Input File"). The data provided by the PBM in this initial MSP Input File shall cover all the periods of coverage for the above-mentioned Active Covered Individuals from **[insert date]** through the last day of the month in which the MSP Input File ("MSP Input File Date") is submitted to CMS.

The PBM, in some instances, may be required to submit files containing prescription drug coverage of Active Covered Individuals on behalf of clients such as Employers, Insurers and other payers that CMS has data sharing agreements with. When the PBM is submitting this information to fulfill its clients reporting obligations, the PBM shall indicate in the specified format provided by CMS, the type of entity that they are submitting for as well as the particular entity that they are submitting on behalf of.

b. On the same date as the PBM's MSP Input File submission as described in C.1 above, the PBM shall submit a File containing the data elements in the Attachment B record layout titled "TIN Reference File." This file contains required PBM group health plan, third party administrator, other plan sponsor and

claims processor TIN information. The PBM shall submit an updated TIN Reference File every quarter/month in which additional TIN records need to be added to the TIN Reference File or when corrections to previously submitted TIN records are required.

c. CMS shall search its Medicare enrollment files for the Active Covered Individuals identified on the PBM's MSP Input File. Where a match occurs, CMS shall annotate its Medicare enrollment files to identify the GHP as a primary payer and Medicare as a secondary payer for the Active Covered Individuals.

d. Within fifteen (15) days of CMS's receipt of the PBM's MSP Input File, for individuals identified under the electronic match conducted pursuant to C.1c., CMS shall provide to the PBM a file containing the data elements listed in Attachment C, labeled "MSP Response File."

e. By (i), the 15th day of the 1st/2nd month following the end of the calendar quarter/month in which the MSP Input File is delivered to CMS, or (ii) within fifteen (15) days after the PBM's receipt from CMS of the MSP Response File for the preceding quarter/month, whichever is later (in either case the "MSP Update File Date"), the PBM shall provide CMS with an MSP Input File containing the data elements listed in Attachment A, effective through the last day of the month in which the MSP Input File ("MSP Update File Date") is submitted to CMS.

This new submission of the MSP Input File will function as the MSP Update File. The MSP Update File shall list (1) the PBM's new reported Active Covered Individuals who now, due to age or Active Employee status, meet the criteria for inclusion in the continuing electronic data exchange ("adds"); (2) previously reported Active Covered Individuals for whom the PBM has not yet received confirmation of Medicare entitlement via the previous CMS Response File ("adds"); (3) changes in status as an Active Employee or in GHP coverage for Covered Individuals identified in earlier submissions ("updates"); and (4) deletions of individuals who were erroneously included on earlier files ("deletes") but for which the PBM subsequently received confirmation of Medicare entitlement via a CMS Response File. (Definitions of the terms "adds," "updates" and "deletes" can be found in the accompanying User Guide.) For individuals included as "adds" on an MSP Update File, CMS shall conduct the matching process set out in C.1.c., and provide Medicare entitlement data to the PBM on the matches as required by C.1.f.

f. Within fifteen (15) days of CMS's receipt of the MSP Update File, CMS shall provide the PBM with the MSP Response File for individuals identified under the electronic match conducted pursuant to C.1.c.

2. Continuing electronic reporting of prescription drug coverage that is supplemental to Medicare Part D

PBMs will have the option of submitting supplemental drug coverage information in the record layout found at Attachment A and receiving Response Files on a quarterly or monthly basis in the record layout found at Attachment C. Using the Agreement Implementation Questionnaire found at Section O, Attachment D of this Agreement, the PBM shall indicate whether it will submit supplemental drug coverage information on a quarterly or monthly basis. The User Guide that accompanies this Agreement contains the specific file submission protocols for each process described below.

If a PBM is providing supplemental drug coverage for a Medicare beneficiary who is classified as an Inactive Covered Individual, on a quarterly/monthly basis, the PBM shall submit this beneficiary information to CMS via a Input File. When a match is found, the coverage information will be applied to CMS's systems and used for prescription drug coordination of benefits. Within fifteen (15) days of CMS's receipt of the Input File, CMS shall provide the PBM with Medicare entitlement data regarding individuals identified through the electronic data match. CMS shall provide these data to the PBM in a file containing the data elements listed in the record layout prescribed in Attachment C. In cases when a match does not occur (that is, Part D enrollment is not confirmed), the information contained on the Input File record will be sent back to the PBM using the same Response File layout, without Medicare entitlement information.

Following the initial Input File, the PBM shall submit regularly scheduled file transfers of ongoing changes in its supplemental drug coverage data, consisting of adds, updates and deletes, except as noted below.

NOTE: In situations where the PBM is reporting supplemental drug coverage information as the agent of an employer or insurer that has signed a data sharing agreement with CMS, the PBM shall have the option of submitting supplemental drug coverage information on behalf of the data sharing partner using either an add, update and delete process or full file replacement process.

When submitting records on behalf of supplemental insurers using the full file replacement process, ongoing Input files shall contain supplemental coverage records of covered individuals whose private drug coverage enrollment terminated up to twenty-seven (27) months prior to the first day of the month in which the Ongoing Input File is generated, or whose private drug coverage enrollment terminated after December 31, 2005, whichever date is most recent. For more specific information regarding these drug coverage enrollment updating processes, please refer to Attachment E, the User Guide.

3. Continuing electronic reporting of SPAP prescription drug coverage that is supplemental to Medicare Part D

In situations where the PBM is reporting drug coverage information as the agent of an SPAP, the PBM shall submit the drug coverage data on behalf of the SPAP using a full file replacement process only.

When submitting records on behalf of supplemental insurers or SPAP partners using the full file replacement process, ongoing Input files shall contain supplemental and/or SPAP coverage records of covered individuals whose private drug coverage enrollment terminated up to twenty-seven (27) months prior to the first day of the month in which the Ongoing Input File is generated, or whose private drug coverage enrollment terminated after December 31, 2005, whichever date is most recent. For more specific information regarding these drug coverage enrollment updating processes, please refer to Attachment E, the User Guide.

4. Continuing electronic reporting of retiree prescription drug coverage for the administration of the Employer Subsidy

Employers wishing to participate in the Employer Subsidy for retiree drug coverage must submit an application to the Retiree Drug Subsidy (RDS) Contractor. The application includes an attestation of the actuarial equivalence of the employer's retiree drug plan to the Medicare Part D drug coverage benefit.

For all retirees for whom it wishes to claim the subsidy, the Employer will be required to submit to the RDS Contractor an initial enrollment file of all those individuals. This first enrollment file will be followed by regularly scheduled subsequent file transfers containing adds, updates and deletes, using a Web portal maintained by the RDS Contractor.

Current regulations specifically authorize the use of Data Sharing Agreements as an alternative method of providing retiree drug subsidy enrollment files to the RDS Contractor. PBM Data Sharing Agreement partners submitting initial enrollment files and subsequent update files for the Employer Subsidy may opt to do so as part of their regular quarterly/monthly Data Sharing Agreements filing using RDS Reporting records. The PBM shall indicate whether it intends to use this process on behalf of its client using the Agreement Implementation Questionnaire, found at Attachment D of this Agreement.

If the Non-MSP Covered Individuals submitted by the PBM for the Employer Subsidy on behalf of its customers are found by CMS to be enrolled in Medicare Part D, CMS shall convert the records of those individuals into supplemental prescription drug coverage reporting as described in C.2., above. The PBM will be notified in the Response File that the records were converted. In subsequent Input File submissions the PBM shall submit adds, updates and deletes for the records converted, as though the records were originally submitted as records reporting drug coverage that is supplemental to Meidicare as described in C.2, above. Note that this provision does not preclude the Employer from re-submitting the original RDS reporting records in an attempt to claim the subsidy

on those individuals previously rejected because they were enrolled in a Part D Plan when the previous file was submitted.

5. Non-Reporting process

Using the N Action Type the PBM may submit records for any Covered Individuals via the Input File. CMS shall search its files for the individuals identified on this Input File. Within fifteen (15) days of CMS's receipt of the Input File, CMS shall provide the PBM with Medicare entitlement data regarding individuals identified through the electronic data match. CMS shall provide these data to the PBM in a file containing the data elements listed in the record layout prescribed in Attachment C. Where a match does not occur, the information on the Input File record will be sent back to the PBM using the same Response File layout, without Medicare entitlement information.

D. CORRECTION OF RECORDS CONTAINING ERRORS

Upon receipt of the PBM's Covered Individuals Initial and Update Files, CMS shall analyze the files to identify any errors and defects in the data provided (such as unreadable entries or data that do not comply with the terms of this Agreement). When it detects errors and/or defects, CMS shall provide to the PBM an MSP Response File and a Non-MSP Response File, containing the data elements in the record layout prescribed in Attachment C, identifying the errors detected on the Initial or Update Files. Recognizing that all Pharmacy Benefit Managers Data Sharing Agreement data is submitter-driven information, the PBM agrees to correct any record errors identified in a Response File, provided such records can be corrected, and to resubmit those records as "add" or “update” records on the next Update File.

E. BASIS - THE BENEFICIARY AUTOMATED STATUS AND INQUIRY SYSTEM APPLICATION

The BASIS application: When the PBM has a more immediate need to know Medicare entitlement, BASIS allows the PBM to make a limited number of on-line queries of Medicare entitlement of its Covered Individuals through a private web-based host. Access to BASIS is contingent on the PBM having submitted its Initial Input Files and its most recent Input Files during the last quarterly/monthly production cycle. Refer to the User Guide for more detail about the BASIS process, outlined as follows:

1. CMS shall (through its designated contractor) assign a PBM personal identification number (“PPIN”) to the PBM. The PPIN information shall be received by the designated PBM Contact Person within 30 days of submission of the initial Input Files, as described in Sections A – D above, along with information concerning the designated telephone line to be used for the BASIS application.

2. CMS shall notify the PBM when the BASIS application is operational and shall provide detailed instructions to assist the Insurer in using the BASIS application.

3. The PBM shall dial a designated telephone line to access the BASIS application using its assigned PPIN. For each Covered Individual for whom the PBM is requesting Medicare entitlement information, the PBM shall enter the following data elements that the PBM maintains in its system concerning that individual:

   - Social Security Number
   - Last Name
   - First Initial
   - Date of Birth
   - Sex
   - HICN (optional)

4. The CMS shall post the results of the above referenced inquiry(s) to BASIS within forty-eight (48) hours after the PBM submitted its inquiry(s) to the BASIS application.

F. Rx BIN AND PCN CODES

Both the Rx BIN and PCN are numbers used in the electronic routing of pharmacy benefit reimbursement information. The prescription Benefit International Number (Rx BIN) and the Pharmacy Benefit Processor Control Number (PCN) are assigned to network pharmacy payers by the American National Standards Institute (ANSI) or, alternatively, by the National Council for Prescription Drug Programs (NCPDP). All network pharmacy payers have an Rx BIN. Many, though not all, also have a PCN. The four data input and response files used by the PBM Data Sharing program (Attachments A and C) include data fields for both Rx BIN and PCN reporting.

To participate in the TrOOP Facilitation process, PBMs should obtain a unique Rx BIN or PCN number to code for coverage that is secondary to Medicare Part D. This unique coding will assure that the secondary paid claim is captured by the TrOOP Facilitation contractor in the claim response sent from the payer to the pharmacy provider. The "TrOOP Facilitation" Rx BIN(s) or PCN(s) will be separate and distinct from the PBM's standard Rx BIN(s) and PCN(s). The regular Rx BIN(s) and PCN(s) shall be provided in MSP File Input Records. The TrOOP Facilitation Rx BIN and PCN are the appropriate routing numbers for Non-MSP Input Records.

When CMS identifies an Inactive Covered Individual on the Non-MSP File as a Medicare Part D beneficiary, the prescription drug coverage and TrOOP Facilitation Rx BIN and PCN routing information will be provided to the Part D plan and the TrOOP Facilitation contractor. By signing this Agreement, the PBM agrees to obtain a TrOOP Facilitation Rx BIN or PCN (if necessary). In addition, the PBM must provide CMS with a list of all its standard and TrOOP facilitation BINs and PCNs within thirty (30) days after it has signed this agreement, or by December 31, 2005, whichever comes first. (See

Number 10, “Miscellaneous: Agreement Implementation Questionnaire, Attachment D,” in Section P of this Agreement).

G. DUTY TO OBTAIN DATA

The PBM may be in possession of some, but not all, of the data elements identified in Attachments A, B and C in the User Guide. With respect to data not originally in its possession, the PBM shall use commercially reasonable efforts to obtain these data as soon as possible. These data should be obtained no later than the first practical enrollment, re-enrollment or renewal date in the Group Health Plan (GHP) as long as this date is no later than six (6) months after the CMS’ receipt of the Input File required by Section C . If necessary data cannot be obtained because an enrollment, re-enrollment or renewal date of the GHP will not occur in the next six (6) months, the PBM shall individually contact each Covered Individual to obtain or correct such data within thirty (30) days of becoming aware, or being notified, that the necessary information about the Covered Individual is missing or is incorrect. The PBM shall include the data corrections received as an "update" in the next Update File delivered to CMS following the collection of the necessary data.

The PBM shall also modify, when necessary, its GHP enrollment, re-enrollment and renewal procedures to routinely capture the data elements identified in Attachments A, B and C before the next enrollment, re-enrollment, or renewal cycle, unless the PBM has an alternative method of capturing this information that is acceptable to CMS. The PBM attests that once the data elements are captured, it will provide this information to CMS when it submits its next update file.

If, following the procedures outlined above for the collection of new and correction of existing data, the PBM is still unable to obtain a particular data element, the Insurer should submit to CMS as much of the remaining information for the Covered Individual as it is able to provide. The PBM shall continue to seek any data for which a request is more than thirty (30) days old.

H. TERM OF AGREEMENT

The PBM and CMS are dedicated to developing and implementing a process for exchanging data that provides CMS and the PBM with quarterly/monthly updates on a regular and consistent basis with minimal interruption to the administration and operations of the Insurer and CMS. Accordingly, the initial term of this Agreement shall be twenty-four (24) months from the Effective Date unless earlier terminated as set forth below, and shall automatically renew for successive twelve (12) month terms unless, not less than ninety (90) days prior to the end of any term, a Party provides the other Party with written notice of its intent not to renew the Agreement. During the initial term of the Agreement, the parties shall diligently and in good faith evaluate the data exchange process and discuss and endeavor to implement modifications to the process in order to achieve the efficiency described in Section II hereof as a principal purpose of the agreement.

During the initial term or any succeeding term of this Agreement, CMS may terminate this Agreement upon sixty (60) days prior written notice to the PBM of the PBM's repeated failure to perform its obligations pursuant to this Agreement, and the PBM's failure during such sixty (60) day period to cure such breach of its obligations by satisfying the conditions set forth in such notice.

During the initial term or any succeeding term of this Agreement, the PBM may terminate this Agreement upon sixty (60) days prior written notice to CMS of CMS's repeated failure to perform its obligations pursuant to this Agreement, and CMS's failure during such sixty (60) day period to cure such breach of its obligations by satisfying the conditions set forth in such notice.

Except as the parties may otherwise agree, this Agreement shall terminate in the event of enactment of any new MSP legislation which contradicts or is inconsistent with the terms of the data exchange portions of this Agreement.

I. SAFEGUARDING & LIMITING ACCESS TO EXCHANGED DATA

The Parties agree to establish and implement proper safeguards against unauthorized use and disclosure of the data exchanged under this Agreement. Proper safeguards shall include the adoption of policies and procedures to ensure that the data obtained under this Agreement shall be used solely in accordance with Section 1106 of the Social Security Act [42 U.S.C. § 1306], Section 1874(b) of the Social Security Act [42 U.S.C. § 1395k(b)], Section 1862(b) of the Social Security Act [42 U.S.C. § 1395y(b)], and the Privacy Act of 1974, as amended [5 U.S.C. § 552a]. The PBM shall establish appropriate administrative, technical, procedural, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized access to the data provided by CMS. The PBM agrees that the authorized representatives of CMS shall be granted access to premises where the Medicare data is being kept for the purpose of inspecting security arrangements confirming whether the PBM is in compliance with the security requirements specified above.

Access to the records matched and to any records created by the matching process shall be restricted to authorized CMS and Insurer employees, agents and officials who require access to perform their official duties in accordance with the uses of the information as authorized in this Agreement. Such personnel shall be advised of (1) the confidential nature of the information; (2) safeguards required to protect the information, and (3) the administrative, civil and criminal penalties for noncompliance contained in applicable Federal laws.

CMS and the PBM agree to limit access to, disclosure of and use of all data exchanged between the Parties. The information provided may not be disclosed or used for any purpose other than to implement MMA and MSP provisions and related laws, and coordinate benefit payments between the PBM and CMS, and as is necessary to prevent or recover mistaken payments. The Parties agree that the eligibility files exchanged by

the Parties shall not be duplicated or disseminated beyond updating the Parties current eligibility files.

J. PRIVACY ACT

Data that are protected in a Privacy Act System of Records (SOR) shall be released from CMS in accordance with the Privacy Act (5 U.S.C. §552a) and CMS data release policies and procedures. The appropriate Privacy Act disclosure exception for these releases is found in System No. 09-70-0536 (Medicare Privacy Database).

The parties agree and acknowledge that they are performing "covered functions" as that term is defined in the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule") under the HIPAA at 45 C.F.R. § 164.501. The parties further agree that the use and disclosure of Protected Health Information between the parties pursuant to this Agreement is for payment as defined in the Privacy Rule. The Parties further agree that the Protected Health Information be used or disclosed pursuant to this Agreement is the minimum necessary to accomplish the intended purposes of this Agreement. The parties agree to abide by all requirements of the Privacy Rule with respect to Protected Health Information used or disclosed under the Agreement.

All data contained in the MSP Input File and all data contained in any Update File (excluding any Medicare data which are provided by CMS to the Insurer on a MSP Response File) shall not be subject to the use and disclosure data requirements found in the regulations described in this Section.

K. RESTRICTION ON USE OF DATA

All data and information provided by the Parties shall be used solely for the purposes outlined in Section III of the Recitals. If the PBM wishes to use the data and information provided by CMS under this Agreement for any purpose other than those outlined above, the Insurer shall make a written request to CMS describing the additional purposes for which it seeks to use the data. If CMS determines that the PBM's request to use the data and information provided hereunder is acceptable, CMS shall provide the PBM with written approval of the additional use of the data.

The terms of this section shall not apply to the PBM with respect to data contained in any MSP or Non-MSP Input files, excluding any Medicare data which are provided by CMS to the PBM in any MSP or Non-MSP Response files.

L. PENALTIES FOR UNAPPROVED USE OR DISCLOSURE OF DATA

The PBM acknowledges that criminal penalties under section 1106(a) of the Social Security Act [42 U.S.C. § 1306 (a)], including possible imprisonment, may apply with respect to any disclosure of data received from CMS that is inconsistent with the purposes and terms of the Agreement. The PBM further acknowledges that criminal penalties under the Privacy Act [5 U.S.C., § 552a(I)(3)] may apply if it is determined that

the PBM, or any individual employed or affiliated therewith, knowingly and willfully obtained the data under false pretenses.

M. PBM CONTACTS

Administrative Contact: The PBM designates the individual listed below as the contact person for administrative or other implementation coordination issues under this Agreement. The contact person shall be the point of contact for the CMS for any administrative questions that may arise during the term of this Agreement. If the PBM changes its administrative contact person, the PBM shall notify the CMS in writing within thirty (30) working days of the transfer and provide the information listed below for the new contact person.

Name:	(Insert Name)
Address:	(Insert mailing address)
Phone #:	(Insert Phone #)
Fax #:	(Insert Fax #)
E-mail:	(Insert E-mail address)

Technical Contact: The PBM designates the individual listed below as the contact person for technical or other implementation coordination issues under this Agreement. The contact person shall be the point of contact for the CMS for any technical questions that may arise during the term of this Agreement. If the PBM changes its technical contact person, the PBM shall notify the CMS in writing within thirty (30) working days of the transfer and provide the information listed below for the new contact person.

Name:	(Insert Name)
Address:	(Insert mailing address)
Phone #:	(Insert Phone #)
Fax #:	(Insert Fax #)
E-mail:	(Insert E-mail address)

N. CMS CONTACTS

Administrative Contacts: The CMS designate the individuals listed below as the contacts for administrative or other implementation coordination issues under this Agreement. The contacts shall be the point of contact for the PBM for any administrative questions that may arise during the term of this Agreement. If the CMS change the administrative contact person(s), the CMS shall notify the PBM in writing within thirty (30) working days of the transfer and provide the information listed below for the new contact person.

Name: John Albert
Phone #: (410) 786-7457
Fax #: (410) 786-7030
E-mail: john.albert@cms.hhs.gov

Name: Aaron Wesolowski
Phone #: (410) 786-8075
Fax #: (410) 786-7030
E-mail: aaron.wesolowski@cms.hhs.gov

Name: Bill Decker
Phone #: (410) 786-0125
Fax #: (410) 786-7030
E-mail: william.decker@cms.hhs.gov

Name: Tracy Richardson
Phone #: (410) 786-7549
Fax #: (410) 786-7030
E-mail: tracy.richardson@cms.hhs.gov

Address: Centers for Medicare and Medicaid Services
Office of Financial Management
Financial Services Group
Division of Medicare Secondary Payer Policy and Operations
Mail Stop: C3-14-16
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Technical Contact: Upon signature of this agreement by both parties, the CMS will designate a Coordination of Benefits Contractor Electronic Data Interchange (EDI) Representative as the contact for technical or other implementation coordination issues under this Agreement. The EDI Representative contact shall be the point of contact for the PBM for any technical questions that may arise during the term of this Agreement. If the CMS change the technical contact person, the CMS shall notify the PBM in writing within thirty (30) working days of the transfer and provide the information listed below for the new contact person.

Name:
Address:
Phone #:
Fax #:
E-mail:

O. MISCELLANEOUS

1. The Parties agree that their respective representatives, whose signatures appear below, have the authority to execute this Agreement and to bind each of the Parties, respectively, to every promise or covenant contained in this Agreement. The Effective Date of this Agreement shall be the last date of execution by the Parties.

2. No alteration, amendment, modification or other change to the Agreement shall be effective without the written consent of the affected Party or Parties. No waiver of this Agreement or of any of the promises, obligations, terms, or conditions contained herein shall be valid unless it is written and signed by the Party against whom the waiver is to be enforced. However, the Parties agree that the User Guide which accompanies this Agreement is not, and is not represented to be, a part of this Agreement.

3. The Parties agree that this Agreement contains all material representations, understandings, and promises of the Parties with respect to this Agreement. The Parties agree that Attachments A through C are representative of the data sets required by this Agreement, but are not necessarily the exact data sets that are to be or will be used by the Parties for the term of this Agreement. This Agreement shall be binding upon the Parties, their successors, and assigns.

4. In the interest of working to protect the confidentiality of MSP Covered Individual and Non-MSP Covered Individual data, information received by the Parties hereto that does not result in a match relevant to this Agreement shall be destroyed within six (6) months following a Party's completion of the matching process. If requested by either Party, each Party to this Agreement shall provide written confirmation to the other Party that all data and information that does not result in a match has been destroyed within that time frame. The Parties further agree that the medium by which the Parties exchange stored data (e.g., round reel tapes, cartridges, CDs) shall be destroyed within one (1) year of receipt.

5. The Parties may transmit the data required to be exchanged under this Agreement electronically, provided the Parties agree on a methodology and format within which to exchange such documentation, and the actual transmission of data is secure.

6. If either Party cannot submit its respective file in a timely manner, at least one week prior to the scheduled release of the file it must notify the other Party that the submission will be late. At that time the date the file will be submitted shall also be provided.

7. The PBM agrees it will inform its related entities, claims processors, third party administrators, and GHPs, to the extent necessary to pay claims, in accordance with the MSP and MMA provisions. The PBM shall share with these entities the MSP and Medicare entitlement information identified as a result of this data exchange for their use in paying claims, in accordance with the MSP provisions.

8. There are no fees payable by either party with respect to this Agreement.

9. Except as specifically provided herein, the rights and/or obligations of either party to this Agreement may not be assigned without the other party's written consent. This Agreement shall be binding upon and shall inure to the benefit of and be enforceable by the successors, legal representatives and permitted assigns of each party hereto.

10. Miscellaneous: Agreement Implementation Questionnaire, Attachment D.

IN WITNESS WHEREOF, the Parties have signed this Agreement on the date indicated below.

Centers for Medicare and Medicaid Services

By: GERALD WALTERS DATE
Director, Financial Services Group
Office of Financial Management

Duly Authorized Representative

(Insert PBM Name)

By: (Insert PBM Representative Name) DATE
(Insert Title)

Duly Authorized Representative

V: 9/7//05